STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations KS00081377, KS00081146, KS00080927, KS00077637, and KS00077536.	F 000		
F 225 SS=C	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1	F 225		

with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 27 residents. Based on record review and interview, the facility failed to perform a background check of 2 of 5 staff members, verify certification on 1 employee, and license verification on 2 employees.

Findings included:

- Record review on 12/4/14 at approximately 11:55 A.M. the employee file for activities staff FF with hire date of 11/12/14 lacked evidence the facility preformed a background check.

Interview on 12/4/14 at 10:06 A.M. administrative staff A acknowledged a background check was not preformed for staff FF. He/she volunteered at the facility for 8 years and became an active employee in November 2014. Administrative staff A stated he/she obtained a background check 12/4/14.

Record review on 12/4/14 at approximately 11:58 A.M. of employee file for dietary staff FF with hire date of 11/14/14 revealed a background check dated 5/9/12. It lacked a current background check.

Interview on 12/4/14 at 12:17 P.M. administrative staff A stated the facility preformed a background check on dietary staff FF in 2012 when he/she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2	F 225		

was a dietary volunteer, but did not perform a background check when he/she became an employee in 2014.

The facility failed to obtain background checks on staff to ensure the safety of the residents.

- Record review on 12/4/14 at approximately 10:30 A.M. of employee file for direct care staff R revealed a hire date of 11/14/14 with a Kansas Survey, Certification, and Credentialing Commission Nurse Aide Registry Confirmation Notice dated 12/4/14.

Record review on 12/4/14 at approximately 10:35 A.M. of employee file for licensed staff K revealed a hire date of 9/25/14 with a Kansas State board of Nursing Official License Verification dated 12/4/14.

Record review on 12/4/14 approximately 10:39 A.M. of employee file for licensed staff L revealed a hire date of 10/21/14 with a Kansas State Board of Nursing Official License Verification dated 12/4/14.

Interview on 12/04/2014 at 12:17 P.M. administrative staff A stated the the facility contracted with a background check company that had a link which took a "snapshot" of the employees certificate or licence but, when printed out, showed the date printed. The facility did not print out the verification on the day the background check was completed. The hiring process included a single person interview with the applicant, then staff called the applicant's references. The facility did not keep the reference information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 The facility provided policy on Resident Protection and Abuse Prevention & Resident Intimacy reviewed June 2008 revealed the facility preformed screening of all potential team members before hire which included reference checks, licensure and/or certification verification, and criminal history. The facility failed to perform background checks, reference checks, and licensure and certification verification to ensure the resident's safety.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility reported a census of 27 residents. The sample included 15 residents. Based on observation, record review, and interview the facility failed to ensure staff addressed residents by their preferred name for 2 (#51, #21). Findings included: - Review of the Electronic Medical Record (EMR) for resident #51 revealed diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). Review of the Admission Minimum Data Set (MDS) dated 8/18/14 revealed a Brief Interview	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4	F 241		

for Mental Status (BIMS) score of 6 which indicated severe cognitive impairment. The resident exhibited disorganized thinking and inattentive behavior, made self understood and could comprehend others.

Review of the MDS dated 11/18/14 revealed a BIMS score of 4 which indicated severe cognitive impairment. The resident was usually understood by other and comprehended others. The resident mood interview revealed a score of 2 which indicated a low risk for depression. No delusion or hallucination were identified.

Review of the cognitive loss/dementia Care Area Assessment (CAA) dated 8/18/14 revealed the resident was able to make simple needs and wants known to staff, staff were to use simple words, phrases, and non-verbal communication such as gestures and facial expressions.

Review of the cognition care plan dated 11/8/14 revealed the staff were to address the resident by name, identify themselves at each interaction, face the resident and make eye contact when speaking to the resident.

On 12/2/14 at 12:41 P.M. staff addressed the resident as "sweetheart".

On 12/4/14 at 11:32 A.M. direct care staff P stated he/she called the resident by his/her first name and staff should not use endearing names for residents.

On 12/4/14 at 11:53 A.M. licensed staff I stated he/she called the resident by his/her first name and it was not acceptable to call the resident by any other name.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5 On 12/4/14 at 12:50 P.M. administrative licensed staff D stated the resident's preferred name was located on the care plan. The staff were provided a dignity in-service in February 2014 which included how to properly address a resident. The facility failed to provide a policy on dignity. The facility failed to provide care in a manner that enhanced this cognitively impaired resident's dignity. - The Significant Change Minimum Data Set (MDS) for resident #21 dated 7/31/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment). The Quarterly MDS dated 10/30/14 revealed the resident had BIMS of 2 (severe cognitive impairment). The Care Area Assessment (CAA) dated 8/7/14 for cognitive loss/dementia revealed the resident had increased cognitive deficits, delusional thinking, and hallucinations at times. The care plan last updated 11/25/14 revealed the resident had impaired cognitive function with impaired thought processes. Staff were to keep the resident's routine consistent and attempt to provide consistent caregivers in order to decrease confusion, provide the resident with a homelike environment, and address him/her by name. During observation on 12/2/14 at 5:01 P.M. licensed staff H addressed resident #21 as "dear heart" and "honey".	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6 On 12/3/14 at 5:55 P.M. the resident ate in the dining room. On 12/04/2014 at 1:13 P.M. direct care staff O revealed the resident's preferred name was documented on the electronic charting system and pet names were not acceptable to use. On 12/04/2014 at 1:21 P.M. licensed nursing staff I stated the name resident #21 preferred staff to call him/her was documented in the care plan and it was not acceptable for staff to address the resident by a name other than what he/she preferred. On 12/04/2014 at 2:50 P.M. administrative nursing staff D stated the resident's preferred name was documented on the care plan, he/she expected staff to address residents by that name, and pet names were not appropriate. The facility failed to provide a policy, as requested, for preserving resident's dignity. The facility failed to provide care in a manner that enhanced the resident's dignity.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	F 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 7	F 244		

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 27 residents. The sample included 19 residents. Based on observation, interview, and record review the facility failed to follow up on concerns voiced by the resident council.

Findings included:

- Review of the monthly resident council meeting minutes from November 2013 to October 2014 revealed 4 months with suggestions that staff remind residents that beer and wine were available during dining.

Review of the monthly resident council meeting minutes from November 2013 to October 2014 revealed 7 months with resident complaints on the quality of food and poor service in the dining room.

Review of the monthly resident council meeting minutes from November 2013 to October 2014 revealed 7 months with resident complaints of slow response to call lights and inconsistent nursing staff.

Interview on 12/4/14 at 2:37 P.M. with a facility resident who was an active member of resident council, revealed there were still ongoing issues with dining services and call lights getting answered. He/she said residents continually voiced these concerns in the resident council meetings. Staff listened to the complaints but call lights and dining were still a problem, and the facility did not fix it.

On 2/4/14 at 2:50 P.M. administrative nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244	Continued From page 8 staff D revealed each department followed up on complaints related to their department. He/she followed up prior to the next month's meeting to ensure the concerns were addressed. The facility failed to provide a policy as requested related to addressing resident council concerns. The facility failed to follow up on and resolve complaints voiced in resident council.	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to accommodate bath preferences for 2 residents (#21 and #51) of the 3 residents reviewed for choices. Findings included: - The Significant Change Minimum Data Set (MDS) for resident #21 dated 7/31/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment).	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 9	F 246		

The Quarterly MDS dated 10/30/14 revealed resident had a BIMS of 2 (severe cognitive impairment).

The Care Area Assessment (CAA) dated 8/7/14 for cognitive loss/dementia revealed the resident had increased cognitive deficits and delusional thinking (untrue persistent belief or perception held by a person although evidence showed it was untrue) and hallucinations (sensing things while awake appeared real, but the mind created) at times.

The care plan last updated 11/25/14 revealed the resident was unable to meet his/her daily hygiene and grooming needs secondary to decreased mobility and cognitive deficits. The resident required assistance with showers and his/her preferred shower time was every Monday and Thursday on the day shift.

Bath charting on the electronic record for 11/5/14 to 12/3/14 revealed the resident received baths 2 times a week on the evening shift.

The care plan meeting update notes dated 6/6/14 and 11/7/14 lacked documentation bathing preferences were reviewed.

On 12/3/14 at 1:16 P.M. the resident ate his/her noon meal in the dining room.

On 12/4/14 at 12:04 P.M. the resident visited with the hospice art therapist in the quiet room.

On 12/04/2014 at 1:13 P.M. direct care staff O stated he/she received information about resident preferences from the electronic charting system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 10	F 246		

On 12/4/14 at 12:10 P.M. administrative nursing staff E revealed staff asked the residents their bathing preference on admission and documented it on the skilled nursing assessment. He/she said bathing preferences were addressed at every care plan meeting.

On 12/04/2014 at 1:21 P.M. licensed nursing staff I stated he/she obtained information about how to care for residents by doing an assessment on admission that generated a care plan and a kardex (a care guide for direct care staff) staff used. The MDS coordinator updated the kardex and care plans and the nurses also did if there were any changes. The resident's care plan revealed he/she preferred baths on Monday and Thursday, on the day shift, and the electronic charting system revealed he/she received them on the evening shift.

On 12/04/2014 at 2:50 P.M. administrative nursing staff D it was every nurse's responsibility to update the care plan and the MDS coordinator reviewed them for accuracy periodically. He/she expected the staff to follow the care plan.

The facility failed to provide a policy for following resident preferences as requested.

The facility failed to provide care according to this resident's preferences.

- Review of the Electronic Clinical Record (ECR) for resident # 51 revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 11	F 246		

Review of the Admission Minimum Data Set (MDS) dated 8/18/14 revealed a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe cognitive impairment. The resident exhibited disorganized thinking and inattentive behavior, made self understood and comprehended others. It was not important at all to choose between a tub bath, shower, bedbath, or sponge bath. The resident was not steady and only able to stabilize with human assistance in moving from seated to standing position, surface to surface transfers, and he/she used a walker and a wheelchair for mobility.

Review of the MDS dated 11/18/14 revealed a BIMS score of 4 which indicated severe cognitive impairment. The resident was usually understood by others and comprehended others. The resident mood interview revealed a score of 2 which indicated a low risk for depression. The resident had no delusional or hallucinatory behaviors. The resident required extensive assistance of one person physical assistance for transfers and personal hygiene.

Review of the cognitive loss/dementia Care Area Assessment (CAA) dated 8/21/14 revealed the resident was able to make simple needs and wants known to staff. Staff were to utilize simple words, phrases, and non-verbal communication such as gestures and facial expressions.

Review of the activities of daily living CAA dated 8/21/14 revealed the resident required extensive assistance and needed cueing to help achieve the highest level of function.

Review of the care plan dated 11/8/14 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 12	F 246		

cognition revealed staff were to engage the resident in simple, structured activities and avoid overly demanding tasks. Staff were to keep the resident's routine consistent in order to decrease confusion.

Review of the skilled Nursing Service Evaluation and Health Assessment dated 8/11/14 at 8:01 P.M. the resident stated he/she preferred showering on Tuesday and Friday mid-morning.

Review of the ECR 12/3/14 at 11:56 AM revealed the resident received a bath/shower on 11/7, 11/11, 11/25 and 12/2/14.

On 12/3/14 at 6:00 P.M. the resident sat calmly in the wheelchair at the dining room table.

On 12/4/14 at 12:15 PM the resident sat calmly in the wheelchair at the dining room table.

On 12/4/14 at 11:32 A.M. direct care staff P stated the resident received a bath twice a week and were scheduled in the computer kardex (a care guide for direct care staff).

On 12/4/14 at 11:53 A.M. licensed staff I stated staff scheduled the resident's bath twice a week and as needed. He/she acknowledged the resident received a bath on 11/7, 11/11 and 11/25/14.

On 12/4/14 at 12:50 P.M. administrative licensed staff D said staff scheduled the resident's bath at least twice a week and as needed. He/she acknowledged the ECR recorded 3 baths for this cognitively impaired resident for the month of November.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 13 The facility failed to provide a policy on resident choices. The facility failed to provide bathing according to this cognitively impaired resident's preference.	F 246		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 27 residents. The sample included 15 residents. Based on observation, record review, and interview the facility failed to update the comprehensive care plan for 4 (#31, #44, #41, #21) of 15 residents	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 14	F 280		

reviewed. (#31 for the dietary supplements, #44 for use of a fall mat, #41 for use a halo transfer bar, and #21 for bathing preferences).

Findings included:

- Review of the Electronic Clinical Record (ECR) for resident #31 revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

Review of the significant change Minimum Data Set (MDS) dated 12/3/14 revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicated severe cognitive impairment. The resident was independent with set up assistance for eating. The resident was 68 inches tall and weighed 134 pounds and had no dental or swallowing issues.

Review of the Care Area Assessment (CAA) dated 12/3/14 for nutrition revealed the plan of care included addressing the nutritional goal to stabilize or increase the resident's weight.

Review of the CAA dated 12/3/14 revealed the resident had cognitive loss due to a diagnosis of dementia.

Review of the nutritional care plan dated 10/27/14 revealed staff set-up the resident's plate and the resident was independent with eating. The family requested the facility not use a dietary supplement.
Review of the skin care plan dated 1027/14 revealed staff were to provide dietary supplement as ordered to promote skin integrity.
Review of the plan of care dated 12/1/14 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 15	F 280		

staff were to serve the resident large portions at meals and cottage cheese at lunch and dinner.

On 12/3/14 at 12:31 P.M. staff brought the resident to the dining room via a wheelchair, positioned him/her at the table, and provided a menu for lunch. The resident chose an omelet and orange juice. At 12:45 P.M. the staff provided an omelet and 1 slice toast. The resident initiated feeding him/herself and consumed all of the orange juice. At 12:51 P.M. staff provided a bowl of cottage cheese and staff refilled the 4 ounce glass of orange juice. At 12:54 P.M. the resident consumed the orange juice, 1/2 slice of toast, 1 ounce of water and 100 percent of ice cream. The resident did not eat the cottage cheese

On 12/3/14 at 5:45 P.M. the resident was asleep in bed with no lights on in the room.

On 12/4/14 at 8:25 A.M. the resident consumed one large bowl of oatmeal with milk, 4 oz orange juice, 2 bites of eggs, and 1/2 slice of toast.

On 12/2/14 the resident stated he/she did not have an issue with the food.

On 12/4/14 at 11:44 A.M. direct care staff P stated the resident himself but did not always come to the dining room for meals.

On 12/4/14 at 12:08 P.M. licensed staff I stated the resident chose what he/she wanted to eat and sometimes did not come to the dining room at dinner.

On 12/04/2014 12:54 P.M. licensed staff J stated the nurses updated the care plan as they received orders to reflect the resident's current

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 16	F 280		

treatment.

On 12/04/2014 1:07 P.M. administrative licensed staff D stated the care plan should reflect the current cares staff provided for the resident.

On 12/4/14 12:42 P.M. administrative licensed staff D stated the staff were to encourage the resident to eat more and honor food preferences. The care plan was updated by staff and the MDS coordinator should update the care plan when the resident had a change in status.

On 12/3/14 at 4:10 P.M. dietary consult GG stated the resident did not receive nutritional supplements per the family's request due to the extra cost for private pay. The last dietary note, 3 months ago, added cottage cheese for additional foods which were included in the meals provided to the resident at no additional cost.

On 12/4/14 at 1:31 PM administrative staff F stated all disciplines updated the care plan. He/she acknowledged the care plan was not individualized to the resident. The nutritional supplement was a dietary supplement and included in the resident's meals at no additional cost to the resident and family.

Review of the undated skilled nursing standards of performance for Individualized Care and Service Plan (ICSP) provided by the facility revealed the staff should individualize and update the ICSP with any permanent change in condition.

The facility failed to update the comprehensive care plan to reflect this cognitively impaired resident's current plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 17	F 280		

- The electronic record for resident #41 revealed a diagnosis of a humerous fracture (a broken arm above the elbow).

The admission Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 8/25/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 1 which indicated severe cognitive impairment. The MDS documented the resident required extensive assistance of two staff with bed mobility, and transfers, and extensive assistance of 1 staff with toilet use, dressing, and personal hygiene. This same assessment noted the resident with unsteady balance, a history of falls, and frequent bowel and bladder incontinence.

The fall Care Area Assessment (CAA) dated 8/26/14 recorded the resident was a high fall risk, had a fall with fracture prior to admission and 2 falls since admission.
The resident's fall risk assessment dated 11/21/14 recorded a score of 15 which placed the resident at high risk for falls (a score greater than 10 indicated high risk).

The resident's revised care plan dated 11/22/14 directed staff to provide assistance with transfers and wheelchair mobility, provide activities that stimulate exercise, provide toileting assistance before and after meals, at bedtime and throughout the night, anti-rollback device for the wheelchair, non-slip shoes, neurological checks after falls, and observe medication regimen for adverse reactions.

The care plan lacked any reference to the use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 18	F 280		

a low bed and/or a fall landing mat.

On 11/25/14 at 11:00 A.M. observation revealed the resident in a low bed with a fall mat/landing pad not in use and leaning against the dresser.

Interview on 11/26/14 at 7:56 A.M. licensed nursing staff H acknowledged the resident used a low bed and fall mat when in bed due to his/her history of falls.

Interview on 12/4/14 at 1:07 P.M. administrative nursing staff D stated the resident's care plan should reflect the cares the resident received.

The undated Skilled Nursing Standards of Performance Individualized Care and Service Plan Policy recorded: residents should not experience a lack of personalization or preferences on the care plan.

The facility failed to update the care plan for this resident who used a fall landing mat and a low bed for protection from falls.

- The electronic record for resident #44 revealed a diagnosis of difficulty in walking.

The admission Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 9/12/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment. The MDS documented the resident required extensive assistance of two staff with bed mobility, and transfers, and extensive assistance of 1 staff with toilet use, dressing, and personal hygiene. This same assessment noted the resident with unsteady balance, no recent history of falls, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 19	F 280		

was frequently incontinent of bowel and bladder.

The fall Care Area Assessment (CAA) dated 9/12/14 recorded the resident was a fall risk, due to cognitive impairment and decreased mobility. The resident's fall risk assessment dated 11/15/14 recorded the resident at times walked independently but was unsafe and had an unsteady gait.

The resident's revised care plan dated 11/22/14 directed staff to provide the resident with a safe environment: room clutter free, hand rails support (halo bar for the bed) (a rounded hand rail positioning bar), and the bed in low position at night.

The care plan lacked reference to the resident's use of a fall mat/landing pad.

On 12/3/14 at 1:08 P.M. observation revealed the resident alert and seated upright in his/her wheel chair. The resident's room lacked a Halo bar on his/her bed, the bed was in low position with a fall mat/landing pad rested against a dresser.

Interview on 12/4/14 at 9:55 A.M. administrative licensed nursing staff E acknowledged the resident used a low bed and fall mat when in bed due to recent falls and he/she was unaware the care plan recorded the resident used a halo bar.

Interview on 12/4/14 at 1:07 P.M. administrative nursing staff D stated the resident's care plan should reflect the cares the resident received.

The undated Skilled Nursing Standards of Performance Individualized Care and Service Plan Policy recorded: residents should not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 20	F 280		

experience a lack of personalization or preferences on the care plan.

The facility failed to update the care plan for this resident who used a fall landing mat and a low bed for protection from falls.

- The Significant Change Minimum Data Set (MDS) for resident #21 dated 7/31/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment).

The Quarterly MDS dated 10/30/14 revealed the resident had a BIMS of 2 (severe cognitive impairment).

The Care Area Assessment (CAA) dated 8/7/14 for cognitive loss/dementia revealed the resident had increased cognitive deficits and delusional thinking (untrue persistent belief or perception held by a person although evidence showed it was untrue) and hallucinations (sensing things while awake appeared real, but the mind created) at times.

The care plan last updated 11/25/14 revealed the resident was unable to meet his/her daily hygiene and grooming needs secondary to decreased mobility and cognitive deficits. The resident required assistance with showers and his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 21	F 280		

preferred shower time was every Monday and Thursday on the day shift.

Bath charting on the electronic record for 11/5/14 to 12/3/14 revealed the resident received baths 2 times a week on the evening shift.

The care plan meeting update notes dated 6/6/14 and 11/7/14 lacked documentation bathing preferences changed.

On 12/3/14 at 1:16 P.M. the resident ate his/her noon meal in the dining room.

On 12/4/14 at 12:04 P.M. the resident visited with the hospice art therapist in the quiet room.

On 12/04/2014 at 1:13 P.M. direct care staff O stated he/she received information about resident care from the electronic charting system.

On 12/4/14 at 12:10 P.M. administrative nursing staff E revealed residents were asked their bathing preference on admission and it was documented on the skilled nursing assessment. He/she said bathing preferences were addressed at every care plan meeting.

On 12/04/2014 at 1:21 P.M. licensed nursing staff I stated he/she obtained information on how to care for residents by doing an assessment on admission that generated a care plan and a kardex (a care guide for direct care staff) staff used. The MDS coordinator updated the kardex and care plans and the nurses also did if there were any changes. The resident's care plan revealed he/she preferred baths on Monday and Thursday, on the day shift, and the electronic charting system revealed he/she received them

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 on the evening shift. On 12/04/2014 at 2:50 P.M. administrative nursing staff D it was every nurse's responsibility to update the care plan and the MDS coordinator reviewed them for accuracy periodically. He/she expected the staff to follow the care plan. The undated Skilled Nursing Standards of Performance Individualized Care and Service Plan policy provided by the facility revealed an individualized care and service plan was initiated at the time of admission and included the resident's choices, preference, and clinical needs. The staff failed to update the resident's care plan to reflect when the resident received baths.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 15 residents. Based on observation, interview, and record review, the facility failed to complete neurological checks for 1 resident (#73) who had an unwitnessed fall. Findings included:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23	F 309		

- The Physician's Order Sheet (POS) for resident #73 dated 12/5/14 to 1/4/15 revealed diagnoses of left hip fracture and advanced dementia (progressive mental disorder characterized by failing memory, confusion).

The Admission Minimum Data Set (MDS) dated 11/28/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 2 (severe cognitive impairment). He/she rejected care 1 to 3 days of the 7 day look back period, required extensive assist of 2 or more people with transfers and toilet use, extensive assistance of 1 with bed mobility, locomotion on the unit, dressing, eating, and personal hygiene, did not walk, required physical help of 1 person in part of bathing, was not steady and only able to stabilize with staff assistance when moving from a seated to standing position, moving on and off the toilet, and with surface to surface transfers, had Range of Motion (ROM) impairment on one side of the lower extremities, and used a wheelchair. He/she had a fall in the last month prior to admission, had a fracture related to a fall in the 6 months prior to admission, and no falls since then.

The Care Area Assessment (CAA) dated 12/2/14 for falls revealed the resident had an increased risk for injury from falls related to cognitive deficits, unsteady gait, and decreased mobility. The resident had a fall prior to admission which resulted in a fracture.

The care plan last updated 11/24/14 revealed the resident had an Activity of Daily Living (ADL) self-care performance deficit related to cognitive impairment and dementia, reduced mobility due to surgical repair of the left hip fracture, used a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24	F 309		

wheelchair for mobility but required staff assistance for mobility of the chair, was dependent on 2 staff member assistance with a gait belt for toilet use, and required the assistance of 2 staff members with a gait belt for transfers.
The care plan last updated 11/24/14 revealed the resident was at risk for falls related to a history of falls with a recent hip fracture. He/she had decreased mobility and balance and poor safety awareness related to dementia. On 11/28/14 the resident had a non-injury fall when he/she rolled from the bed. Staff anticipated and met the resident's needs, assisted him/her to the toilet upon arising, before and after each meal, at bedtime and with each bedcheck during the night, assisted him/her to reposition 3 to 4 times each shift, and ensured the resident wore appropriate slip resistant footwear for all transfers. Staff ensured the bed was in low position and a fall mat placed beside the resident's bed.
A fall investigation provided by the facility revealed on 11/28/14 at 12:45 P.M. the resident fell in his/her room next to the bed while attempting to transfer him/herself. The resident was alone at the time of the fall and the fall was unwitnessed. The resident was found lying on the floor on his/her back with his/her feet in the chair.

The clinical record lacked documentation staff completed neurological checks following the fall.

On 12/3/14 at 3:00 P.M. the resident ambulated in the hallway with therapy.

On 12/4/14 at 8:46 A.M. the resident attempted to transfer him/herself to the toilet and a staff member assisted the resident with transferring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 25 On 12/04/2014 at 1:51 P.M. direct care staff Q revealed the resident was at risk for falls. Staff kept the bed in low position and the call light in reach, had a fall mat, and transferred the resident with assistance of 1 person. On 12/4/14 9:20 A.M. licensed nursing staff I revealed staff filed neurological checks on the chart when they were completed. Prior to that they were kept on the clip board. Licensed nursing staff I acknowledged the clinical record lacked neurological checks for resident #73 following his/her unwitnessed fall. On 12/4/14 at 2:50 P.M. administrative nursing staff D stated staff completed neurological checks on unwitnessed falls and any fall when a resident hit his/her head. The facility failed to provide a policy as requested related to neurological checks. The facility failed to appropriately assess this resident following an unwitnessed fall.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26	F 323		

The facility identified a census of 27 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to address falls for 2 of 3 sampled residents (#41, #44) related to neurological checks after a fall, the use of preventative equipment and failure to thoroughly investigate falls. The facility further failed to maintain an environment free of accident hazards related to an unlocked open and accessible electric stove in the common activity area, and unlocked, open and accessible chemicals, and tools, which presented a potential hazard for 6 confused and independently mobile residents.

Findings included:

- The electronic record for resident #41 revealed a diagnosis of a humerous fracture (a broken arm above the elbow).

The admission Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 8/25/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 1 which indicated severe cognitive impairment. The MDS documented the resident required extensive assistance of two staff with bed mobility and transfers, and extensive assistance of 1 staff with toilet use, dressing, and personal hygiene. This same assessment noted the resident had an unsteady balance, a history of falls, and frequent bowel and bladder incontinence.

The fall Care Area Assessment (CAA) dated 8/26/14 recorded the resident was a high fall risk, had a fall with fracture prior to admission, and 2 falls since admission.
The resident's fall risk assessment dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27	F 323		

11/21/14 recorded a score of 15 which placed the resident at high risk for falls (a score greater than 10 indicated high risk).

The resident's revised care plan dated 11/22/14 directed staff to provide assistance with transfers and wheelchair mobility, provide activities that stimulate exercise, provide toileting assistance before and after meals, at bedtime and throughout the night, anti-rollback device for the wheelchair, non-slip shoes, neurological checks after falls, and observation of the medication regimen for adverse reactions.

On 11/25/14 at 11:00 A.M. observation revealed the resident in a low bed with a fall mat/landing pad not in use and leaning against the dresser.

On 11/25/14 at 12:00 P.M. observation revealed the resident in bed with his/her fall mat not in place.

On 11/26/14 at 7:45 A.M. the resident was in bed with his/her landing pad resting against a dresser.

Interview on 11/26/14 at 7:56 A.M. licensed nurse H acknowledged the resident used a low bed and fall mat to help prevent falls.

Interview on 11/26/14 at 9:45 A.M. with direct care staff O stated the resident required total assistance. He/she said the staff did not leave the resident in his/her room up in the wheelchair without supervision to prevent falls and staff used a fall mat when the resident was in bed.

On 11/26/14 at 1:30 P.M. observation revealed the resident in a low bed with the landing pad across the room and against the wall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28	F 323		

Interview on 11/26/14 at 2:50 P.M. administrative licensed nurse D stated staff removed the resident's fall mat as the interdisciplinary team thought it might cause injury.

On 12/2/14 at 1:30 P.M. observation revealed the resident seated on the side of bed with both his/her feet on a fall mat beside the bed. The resident had only socks on his/her feet.

Interview on 12/4/14 at 9:01 A.M. direct care staff P said he/she was not aware if the resident used a protective fall mat.

Interview on 12/4/14 at 11:54 A.M. administrative licensed nurse E stated the resident attempted to get up from wheelchair and the bed, and as prevention, staff used an autolock on his/her wheelchair, kept a clear path in the resident's room, and used a hi-low bed.

The undated Skilled Nursing Standards of Performance Falls Management Policy recorded: The Individual Care Service Plan (ICSP) identified fall risk through individualized approaches designed to assist in the prevention of falls. Appropriate safety devices used were bed/chair alarms, floor mats, and low bed positioning; and Team members would have knowledge of the residents' limitations.

The facility failed to consistently implement and address fall safety devices for this resident who the facility care planned to use a fall landing mat, non-skid shoes, and a low bed for protection from falls.

- The electronic record for resident #44 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29	F 323		

a diagnosis of difficulty in walking.

The admission Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 9/12/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment. The MDS documented the resident required extensive assistance of two staff with bed mobility, and transfers, and extensive assistance of 1 staff with toilet use, dressing, and personal hygiene. This same assessment noted the resident with unsteady balance, no recent history of falls, and was frequently incontinent of bowel and bladder.

The fall Care Area Assessment (CAA) dated 9/12/14 recorded the resident was a fall risk, due to cognitive impairment and decreased mobility. The resident's fall risk assessment dated 11/15/14 recorded the resident at times walked independently but was unsafe and had an unsteady gait.

Review of the electronic clinical record revealed the resident fell while attempting self transfers on 11/1/14 at 10:00 P.M., on 11/12/14 at 10:25 A.M. and 11/30/14 at 12:30 P.M.
On 11/1/14 staff found the resident in his/her room (the investigation lacked where and in what position staff found the resident).
On 11/12/14 staff found the resident on the floor next to his/her bed (the investigation lacked documentation if the bed was in the low position and/or if the fall mat was used).
On 11/30 the investigation documented staff found the resident on the floor (near the nursing office) lying supine and the recorded the staff found the resident on the floor seated upright.
The fall investigation lacked documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 30	F 323		

specifically where the resident fell and what position he/she was found in.

The resident's revised care plan dated 12/1/14 recorded the resident fell on 11/30/14 while trying to transfer his/herself but lacked documentation concerning how the resident fell on 11/1/14 and 11/12/14. The care plan directed staff to provide the resident with a safe environment: room clutter free hand rails support (halo bar for the bed) (a rounded hand rail positioning bar), and bed in low position at night.

On 12/3/14 at 1:08 P.M. observation revealed the resident was alert and seated upright in his/her wheel chair. The resident's room lacked a halo bar on his/her bed and the resident's bed was in low position with a fall mat/landing pad resting against a dresser.

Interview on 12/3/14 at 5:13 P.M. the resident stated he/she fell once at the facility while trying to get from his/her wheelchair to the bathroom.

Interview on 12/4/14 at 9:55 A.M. administrative licensed nursing staff E acknowledged the resident used a low bed and a fall mat when in bed due to recent falls and he/she was unaware the care plan recorded the resident used a halo bar.

The undated Skilled Nursing Standards of Performance Falls Management Policy recorded: falls would have the appropriate investigation and follow up documented in the guest's health information.

The facility failed to thoroughly investigate falls and failed to consistently implement interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 31 for this resident who experienced falls. - On 12/2/14 at 10:05 P.M. during the initial tour of the facility the activities kitchen stove lacked a safety lock out, and residents were in the room at this time. On 12/3/14 at 7:33 A.M. 3 residents were in wheelchairs in the activity room. There were no staff in the activity room or at the nurses' station which had direct visualization to the stove area. On 12/4/14 at 8:21 A.M. there were no staff but 3 residents were in wheelchairs in the activity room. No staff were at the nurses station either. On 12/4/14 at 10:23 A.M. activities director LL stated there was no safety lock out on the stove. On 12/4/14 at 12:26 P.M. administrative licensed staff D stated the stove was used for activities and did not have a safety lock out. The facility failed to provide a policy on safety for the use of a stove in the activity room. The facility failed to provide a safe environment related to an unlocked and accessible electric stove. - On 12/3/14 at 6:03 P.M. an "unlockable" room contained a wall paper scraper, a tile adhesive towel square with sharp edges, and an opened	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 32 bucket (without a lid) of approximately 4 gallons of an unidentified white liquid. On 12/3/14 at 6:05 P.M. administrative licensed staff D acknowledged the staff should not keep unsecured chemicals and tools available to cognitively impaired and independently mobile residents and were moved to a secure room. Review of the Chemical Safety:Resident Risk Reduction policy dated 11/11/05 revealed chemicals were not accessible to residents, chemicals would always be in approved containers and properly labeled. Staff were not to leave an "unlockable" cabinet unattended if stocked with chemicals. The facility failed to keep the resident's environment free from potential accident hazards.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 27 residents. The sample included 15 residents, 5 of which were reviewed for medications. Based on observation, record review, and interview, the facility failed to adequately monitor behaviors for 2 (#21 and #73) of the 5 residents reviewed for medications. Findings included: - The Significant Change Minimum Data Set (MDS) for resident #21 dated 7/31/14 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment). He/she had hallucinations (sensing things while awake that appeared real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue), and received antianxiety medication (medication to treat anxiety-mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and antidepressant medication (medication to treat depression-abnormal emotional state characterized by exaggerated	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 34	F 329		

feelings of sadness, worthlessness and emptiness) 7 of 7 days of the look back period. The Quarterly MDS dated 10/30/14 revealed the resident had a BIMS of 2 (severe cognitive impairment). He/she received antianxiety and antidepressant medication 7 of 7 days of the look back period.

The Care Area Assessment (CAA) dated 8/7/14 for cognitive loss/dementia revealed the resident had increased cognitive deficits, delusional thinking, and hallucinations at times.

The CAA dated 8/7/14 for psychotropic drug use revealed the resident had a potential for adverse effects related to the use of scheduled Ativan (an antianxiety medication) for symptoms of anxiety and daily antidepressant use.

The CAA dated 8/7/14 for mood state revealed the resident became anxious and tearful.

The care plan last updated 11/25/14 revealed the resident became verbally disruptive and agitated and hollered out at staff, visitors and/or other residents. Staff observed for inappropriate behaviors and documented them, observed for signs and symptoms of agitation and intervened with non-medicinal interventions to avoid increased agitation, and monitored and documented side effects and effectiveness of medications.

Nurse's notes on 9/14/14 at 11:55 A.M. revealed the resident was really agitated, very tearful and crying. He/she received Ativan and settled down after a while.

Social services note on 10/21/14 at 4:33 P.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 35	F 329		

revealed the resident continued to have crying episodes.

Nurse's notes on 11/1/14 at 1:27 P.M. revealed the resident was agitated, stating that people killed his/her spouse. He/she refused to eat lunch.

Nurse's notes on 11/26/14 at 5:40 P.M. revealed the resident shouted and yelled in the activity room.

The clinical record revealed orders for Zoloft 75 milligrams (mg) by mouth daily for depression ordered 3/27/14 and Ativan 0.5 mg by mouth daily at 11:00 A.M. for agitation ordered 6/131/4.

The October 2014 behavior sheets had incomplete documentation on 4 of 31 day shifts, 3 of 31 evening shifts, and 3 of 31 night shifts.

The November 2014 behavior monitoring sheet had incomplete documentation on 30 of 30 day shifts, 25 of 30 evening shifts, and 11 of 30 night shifts.

The December 2014 behavior monitoring sheet had incomplete documentation on 4 of 4 day shifts and 3 of 3 evening and night shifts.

On 12/2/14 at 5:00 P.M. staff administered the resident's medication without difficulty.

On 12/3/14 at 3:00 P.M. the resident participated in an activity in the living room.

Interview on 12/04/2014 at 1:13 P.M. with direct care staff O revealed the resident was confused, cried, and was verbally combative. Direct care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 36	F 329		

staff documented behaviors in the electronic charting system.

Interview on 12/04/2014 at 1:21 P.M. licensed nursing staff I revealed the resident received Ativan scheduled at 11:00 A.M. Staff documented behaviors on residents who received antidepressant medications and some other medications. Staff completed behavior documentation on resident #21 for behaviors of yelling and crying and acknowledged behavior charting was not complete. The physician and staff used the documentation of the resident's behaviors to adjust the resident's medication dose. He/she stated staff could not get an accurate picture of the resident's behaviors if the charting was not complete.

Interview on 12/04/2014 at 2:50 P.M. revealed administrative nursing staff D stated staff completed behavior monitoring on residents who received antidepressant medication if they called out a lot so staff could see if the medication helped. He/she expected staff to document every shift.

The undated Skilled Nursing Standards of Performance Anti-Psychotic/Psychoactive Utilization Management policy provided by the facility revealed residents should experience ongoing reassessment and observation to evaluate effectiveness of medication regimen.

The facility failed to monitor the effectiveness of medications for this resident who received antianxiety and antidepressant medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 37	F 329		

- The Admission Minimum Data Set (MDS) dated 11/28/14 revealed resident #73 had a Brief Interview for Mental Status (BIMS) score of 2 (severe cognitive impairment). He/she rejected care 1 to 3 days of the 7 day look back period and received antidepressant medication (medications to treat depression-abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) 7 days of the 7 day look back period. The Care Area Assessment (CAA) dated 12/2/14 for psychotropic drug use revealed the resident had a potential for adverse effects related to daily use of antidepressant medication.

The CAA dated 12/2/14 for behavior symptoms revealed the resident was resistive to care at times.

The care plan last updated 11/24/14 revealed the resident was resistive to care at times, refused medications, and refused assistance with eating and self-care.

The care plan last updated 11/24/14 revealed the resident was at risk for adverse reactions related to use of Black Box Warning Medications. Staff observed the resident daily for possible signs and symptoms of adverse drug reaction.

Nurse's notes on 11/24/14 at 1:10 A.M. revealed the resident was uncooperative at times with care and refused staff to remove his/her dentures on 2 to 10 shift.

Nurse's notes on 11/28/14 at 2:38 P.M. revealed the resident refused breakfast and swung his/her hand at staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 38	F 329		

Nurse's notes on 11/29/14 at 2:20 P.M. revealed the resident swung his/her hand when staff tried to help feed him/her.

Nurse's notes on 12/1/14 at 6:14 A.M. revealed the resident became combative with staff who tried to help him/her and hit and slapped staff.

Nurse's notes on 12/1/14 at 11:16 A.M. revealed the resident was restless and refused to take medications and eat breakfast. He/she was combative and hit staff during care.

The resident's clinical record revealed an order for Zoloft (an antidepressant medication) 50 milligrams (mg) by mouth daily ordered on 11/20/14.

The resident's clinical record lacked behavior monitoring for this resident for November and December 2014.

On 12/3/14 at 4:35 P.M. nursing staff took the resident's blood pressure and administered his/her medication.

On 12/3/14 from 5:45 P.M. to 6:25 P.M. the resident sat in the dining room for the evening meal. He/she voiced complaints repeatedly about not being able to find his/her pants. Staff attempted to redirect the resident over and over unsuccessfully.

Interview on 12/04/2014 at 1:51 P.M. with direct care staff Q revealed the resident yelled out continuously and shook his/her fist at staff. Direct care staff charted behaviors in the electronic clinical record and told the nurse about the behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 39 Interview on 12/04/2014 at 2:16 P.M. with licensed nursing staff I revealed the resident refused care and called out a lot. He/she acknowledged the resident's behavior sheets were blank. He/she said the resident received Zoloft and staff should chart behaviors. Interview on 12/04/2014 at 2:50 P.M. revealed administrative nursing staff D stated staff completed behavior monitoring on residents who received antidepressant medication if they called out a lot so staff could see if the medication helped. He/she expected staff to document every shift. The undated Skilled Nursing Standards of Performance Anti-Psychotic/Psychoactive Utilization Management policy provided by the facility revealed residents should experience ongoing reassessment and observation to evaluate effectiveness of medication regimen. The facility failed to monitor the effectiveness of medications for this resident who received antianxiety and antidepressant medications.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 40	F 371		

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 27 residents. Based on observation, interview, and record review, the facility failed to clean food surfaces in a sanitary manner and label opened food containers for 2 of 3 days onsite of the survey.

Findings included:

- On 12/2/14 at 9:25 A.M. during initial tour observed revealed food particles on equipment storage shelves. The walk-in freezer had a bag of unidentified food, food particles, and chunk of ice on the floor. The cold table contained 3 wrapped packages of cheese, one container of ham, one bag of hard boiled eggs, and 8 trawled meat patties, all unlabeled with no opened date. The was an opened container of liquid eggs with no opened date.

Interview on 12/2/14 at 9:25 A.M. during initial tour dietary staff EE acknowledged the opened and undated food items. He/she stated staff were to label and date food items when opened.

On 12/2/14 at 9:52 A.M. during initial tour, the kitchenette had a disposable glove on the floor, the walls and outside the refrigerator with food splatters.

On 12/3/14 at 5:45 P.M. dietary staff DD acknowledged the kitchenette refrigerators were dirty on the outside. He/she stated staff cleaned them weekly.

The facility provided Dietary Supervisor Job

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 41 Description updated 7/1/2007 revealed the dietary supervisor ensured safe food handling was practiced at all times to prevent an outbreak of food borne illness, supervised and completed daily, weekly, and monthly cleaning assignments. The facility failed to store, prepare, and distribute food in a sanitary manner.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 42	F 441		

hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility recorded a census of 27 residents. Bases on observation, record review, and interview the facility failed to properly clean a resident's room who was in isolation and failed to properly store equipment used in an isolation room.

Findings included:

- On 12/3/14 at 3:10 P.M. housekeeping staff Y donned an isolation gown and gloves. He/she carried a container of bleach based cleaning wipes, a red isolation waste bag and a clear plastic bag with the toilet cleaner and toilet cleaning brush into the room. He/she placed the bagged toilet cleaning items on the unclean bathroom floor. He/she started cleaning in the bathroom at the bathroom sink, proceeded to the toilet riser frame, toilet grab bars, toilet and toilet plumbing. He/she placed the toilet cleaner into the toilet and cleaned with the toilet brush, then placed both items into the carrier inside the clear plastic bag. He/she changed gloves and carried the container of bleach based cleaning wipes and bagged toilet cleaning items out of the room and placed them in the housekeeping cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 43 On 12/4/14 at 8:50 A.M. housekeeping supervisor Z acknowledged staff should clean resident rooms from clean to dirty areas. Review of the undated cleaning process provided by the facility revealed the staff should clean in a methodical fashion cleaning from cleanest to dirtiest. Review of the undated policy for Control of Multidrug-Resistant Organism Infection revealed staff should give special attention to the environmental cleaning. The facility failed to provide a procedure on how to clean an isolation room. The facility failed to properly clean an isolation room to minimize transmission of infections, - Observation on 12/3/14 at 3.40 P.M. licensed staff H walked into resident #64's room who was on isolation precautions with diagnosis of resistant infectious microorganism (Vancomycin-resistant Enterococcus (VRE) bacterial strains of the genus Enterococcus that were resistant to the antibiotic Vancomycin) . Licensed staff H removed the stethoscope from around his/her neck and checked placement of resident's peg tube (a tube inserted into the stomach for nutritional feeding). At 4:10 P.M. licensed staff H dropped the stethoscope on the floor beside the resident's bed, picked it up, then placed it around his/her neck. He/she washed his/her hands and placed the stethoscope on the resident's chair by the bathroom door. After	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175499	A. BUILDING _____ B. WING _____	12/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 44	F 441		

washing his/her hands, he/she picked up the stethoscope, placed it around his/her neck, and walked out of the resident's room.

Interview on 12/3/14 at 4:25 P.M. administrative nursing staff D stated residents in isolation precautions should have equipment designated for only their use in the room, which included stethoscopes.

The facility provided policy for Control of Multidrug-Resistant Organism (MDRO) Infection, undated, revealed VRE may contaminate the environment; therefore, staff should give special attention to environmental cleaning.

The facility provided policy for Contact precautions, undated, revealed staff dedicated equipment to a single resident. If equipment must be removed from the room, it must be adequately cleaned and disinfected before another resident's use.

The facility failed to maintain clean equipment to prevent the spread of infection.